

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12557

1. PLACE OF DEATH

a. COUNTY

Howard

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY

Howard

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Gravel Road

c. LENGTH OF STAY IN 1b

1/4 mile south Waterloo Road

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Laurel

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

ROLAND

ANDERSON

4. DATE OF DEATH

Month

Day

Year

Dec.

17

1956

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

August 28, 1939

9. AGE (In years last birthday)

35 17 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10b. KIND OF BUSINESS OR INDUSTRY

High School

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Clarence W. Anderson

14. MOTHER'S MAIDEN NAME

Sarah Elizabeth Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Sarah E. Anderson Laurel, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Gunshot wound of brain

INTERVAL BETWEEN
ONSET AND DEATH976X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

Shot self in head

20c. TIME OF INJURY
Hour a. m.

1:30 p. 12/17 56

Month, Day, Year

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

street

20f. (City or town)

Waterloo

(County)

Howard

(State)

Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and find that death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined cause ☐.ACTUAL
SIGNATURE

William V. Lovitt, Jr.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S
NAME (Type)

William V. Lovitt, Jr., M.D.

DEPUTY MEDICAL EXAMINER ☐

12/18/56

22a. BURIAL, CREMATION,
(Specify)

22b. DATE THEREOF

Dec 19-1956

22c. NAME OF CEMETERY OR CREMATORY

Loyd Hill

22d. LOCATION (City, town, or county)

Laurel Prince Geo. Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Laurel Md.

24a. REC'D BY REGISTRAR

DATE C 26 1956

24b. REGISTRAR'S SIGNATURE

L. H. Hedrich

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Howard

1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12550

Reg. Dist. No.

12568

1. PLACE OF DEATH a. COUNTY Howard				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland				b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Florey Road				d. STREET ADDRESS Florey Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RUTH A. N. BECKER				4. DATE OF DEATH Month Day Year Dec. 14, 1956				9. AGE (In years last birthday) 49 yrs.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25, 1906		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Calvert Co. Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Wm. Lomax				14. MOTHER'S MAIDEN NAME Nora Elliott							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Carl Becker, Hanover, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE George E. Burgtorf				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12-14-56			
EXAMINER'S NAME (Type) George E. Burgtorf M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 17/56		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witke				ADDRESS 4101 Edmondson Ave				24a. REC'D BY REGISTRAR DEC 18 1956		24b. REGISTRAR'S SIGNATURE E. Bird Killian	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 17 1956
BUREAU V.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12551

Reg. Dist. No. 190

Items 10a, 13, 14, 15, 16, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. PLACE OF DEATH a. COUNTY Howard 12569 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Georgia b. COUNTY Dougherty	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge Route 1		c. LENGTH OF STAY IN 1b Albany	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 24 Box 18		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN WILLIS BRIDGES		4. DATE OF DEATH Month Day Year Dec. 26, 1956 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed	8. DATE OF BIRTH Jan. 8, 1928
9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Georgia	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? Georgia	
13. FATHER'S NAME Unknown Sidney Willis Bridges		14. MOTHER'S MAIDEN NAME Unknown Eva D. Bridges	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 2		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Rt. 24, Box 18, Albany, Ga.		18. ADDRESS Personal papers	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 973.1 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 Hours		INTERVAL BETWEEN ONSET AND DEATH 3 Hours	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) motor running Piped exhaust gas into car with hose all windows closed	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6.30 PM 12-26-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 1 Elkridge		20f. (City or town) (County) (State) Elkridge Howard Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George E. Burgtorf		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George E. Burgtorf MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		12-26-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-28-56	
22c. NAME OF CEMETERY OR CREMATORY Albany		22d. LOCATION (City, town, or county) (State) Albany, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.		24a. REC'D BY REGISTRAR 12/31/56	
24b. REGISTRAR'S SIGNATURE E. B. Williams		DATE	

RECEIVED
DEC 31 1956
BUREAU V. 8

RECEIVED
DEC 31 1956
BUREAU V. 8

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12552

Item 7 Film G208 12-28-56 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Md. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jonestown		c. LENGTH OF STAY IN 1b 2 wk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) JOYCE LARUE BRIGHT		4. DATE OF DEATH Dec. 16 1956	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-1936
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) DAYTON, MD.
13. FATHER'S NAME PHILLIP BRIGHT		14. MOTHER'S MAIDEN NAME SARAH BRIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Confluent bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pituitary, adrenal and thyroid hypoplasia			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-19-56	22c. NAME OF CEMETERY OR CREMATORY BROWNS CHAPEL
23. FUNERAL DIRECTOR'S SIGNATURE F.C. HIGDON		24a. REC'D BY REGISTRAR DEC 21 1956	
		24b. REGISTRAR'S SIGNATURE R. H. Hedrick	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REPORTED BY

MR.

HOWARD

DAYTON

2 WK

LOWENBERG

DEATH

DEATH

1956

16

DEC.

DEATH

DEATH

DEATH

DEATH

20

20

20

CONFIDENTIAL INFORMATION

CONFIDENTIAL INFORMATION

BUREAU V. 3

DEC 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5, Film G209, 1/7/57 fcy **CERTIFICATE OF DEATH**

Reg. Dist. No. **12553**

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge	
c. LENGTH OF STAY IN lb 15 yrs		d. STREET ADDRESS Rockburn Hill, Elkridge, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None, Rockburn Hill Elkridge, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma E. B. Brown		4. DATE OF DEATH Dec. 30, 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1898
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Ill.	
11. BIRTHPLACE (State or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William Bielefeld		14. MOTHER'S MAIDEN NAME Martha Woller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 10		16. SOCIAL SECURITY NO.	
17. INFORMANT Thomas E. Brown Sr. Rockburn Hill, Elkridge		Address	
18. CAUSE OF DEATH* [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO 171x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of cervix DUE TO metastases to abdominal organs (c) metastases to abdominal organs		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Dec 56 to 29 Dec 56 , that I last saw the deceased alive on 29 Dec 56 , and that death occurred at AM M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George E. Groleau M.D.		ADDRESS (Street, city or town, state) Elkridge 27, Md	
PHYSICIAN'S NAME (Type) GEORGE E. GROLEAU		DATE SIGNED 31 Dec 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-56	
22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge		22d. LOCATION (City, town, or county) (State) Howard Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	
24a. REC'D BY REGISTRAR JAN 2 1957		24b. REGISTRAR'S SIGNATURE Ed Williams	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12572

CERTIFICATE OF DEATH

12554

Reg. Dist. No.

191

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City R. F. D. #3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Frederick Rd.				d. STREET ADDRESS Old Frederick Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MINNIE Middle V. Last BUCKINGHAM				4. DATE OF DEATH Month Dec. Day 9, Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1872		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George A. Suter				14. MOTHER'S MAIDEN NAME Mary C. Robinson Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. H. G. Morris - Old Frederick Rd. Ellicott City R. F. D. #3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration & malnutrition 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis of Pancreas DUE TO (c) Arteriosclerosis, generalized severe							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Nov 15 , 19 55 , to 10 Dec , 19 56 , that I last saw the deceased alive on 10 Dec , 19 56 , and that death occurred at 5:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William J. Bryson				ADDRESS (Street, city or town, state) 4605 Elmwood Ave			
PHYSICIAN'S NAME (Type) William J. Bryson				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/12/56		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Son - Balto.				24a. REC'D BY REGISTRAR DATE 12/11/56		24b. REGISTRAR'S SIGNATURE J. E. Longhans	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 48

RECEIVED

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12555

12573

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ref</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DeLoe</u> Middle <u>-</u> Last <u>Griffin</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1892</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hampton Hosp.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Nathan Hendrix</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hopkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>219-36-7241</u>			
17. INFORMANT <u>Louise Lewis - Hampton, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA Breast, METASTASIS to LUNG,</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Liver, Spleen, Brain, Bronchial pneumonia.</u> DUE TO (c) <u>Left hemiplegia.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>MARCH 56</u> <u>DEC 56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>56</u> , to <u>22 DEC</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>22 DEC</u> , 19 <u>56</u> , and that death occurred at <u>8:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Sikesville, Md</u> DATE SIGNED <u>22 Dec 56</u>			
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>				<u>SIKESVILLE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-26-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty</u>		22d. LOCATION (City, town, or county) (State) <u>Alpha, Howard Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur N. Haight - Sikesville, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 12-25-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Keen</u>	

BUREAU V. S.

DEC 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12574

CERTIFICATE OF DEATH

12556

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. LENGTH OF STAY IN 1b <u>10 mo. 22 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Taylor Manor Hospital</u>				d. STREET ADDRESS <u>2515 Foster Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>JANKOWIAK</u> Last <u>JANKOWIAK</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1888 3 67 33</u>	9. AGE (In years last birthday) <u>67 33</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS JANKOWIAK</u> <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>MARY WAWRZYNIAK</u> <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>316-07-6396</u>		17. INFORMANT <u>Mrs. Margaret Gasior, 743 S. Curley St. Balto.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> <u>3 months</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome resulting from Cerebral Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 18</u> , 19 <u>56</u> , to <u>Dec. 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 10</u> , 19 <u>56</u> , and that death occurred at <u>4:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irving J. Taylor</u> M.D.				DATE SIGNED <u>TAYLOR MANOR HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>Irving J. TAYLOR</u>				<u>ELLICOTT CITY, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>DEC. 13 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		22d. LOCATION (City, town, or county) (State) <u>1300 DUNDALK AVE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Q. Weber 745 S. Penn st</u>				24a. REC'D BY REGISTRAR <u>12/11/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Loughran</u>	

RECEIVED

12575

CERTIFICATE OF DEATH

12557

Reg. Dist. No. 191

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Indelphin Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LLOYD M. LAWSON</u> First Middle Last				4. DATE OF DEATH <u>12/26/56</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/19/1895</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>WWI</u>			
17. INFORMANT <u>Mrs Elizabeth W. Lawson</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute & Chronic Renal Congestive</u> <u>260X</u> DUE TO <u>Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Degenerative Heart Disease</u> DUE TO <u>Dilated Myocarditis</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Below Knee Amputation leg Right old</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>56</u> (County) <u>12/26/56</u> (State)				21. I certify that I attended the deceased from <u>Sept 56</u> , 19 <u>56</u> , to <u>12/26/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/26/56</u> , 19 <u>56</u> , and that death occurred at <u>100 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. Mc Grath M.D.</u>				ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville 28md</u> DATE SIGNED <u>12/27/56</u>			
PHYSICIAN'S NAME (Type) <u>W. E. Mc Grath M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>		22d. LOCATION (City, town, or county) <u>Baltimore Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Mc Grath M.D.</u> ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR <u>12/31/56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>John H. Bloughman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
SALES MAN		HIGH SCHOOL		MARRIED		METHODIST		WHITE		WHITE		BROWN		BLUE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
HEART DISEASE		SUICIDE		HOME		JAN 15 1968		10:00 AM		10:00		00		00	
PHYSICIAN		HOSPITAL		CORONER		BURIAL		CREMATION		OTHER		REMARKS		SIGNATURE	
DR. J. H. BROWN		ST. JOHNS HOSPITAL		JOHN J. SMITH		ST. JOHNS CEMETERY		NO		NO		NO		NO	
DATE OF REPORT		REPORTED BY		REPORTED BY		REPORTED BY		REPORTED BY		REPORTED BY		REPORTED BY		REPORTED BY	
JAN 16 1968		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN	

RECEIVED
DEC 21 1956
BUREAU V. B.

12576 CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>1-266</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> 4 Mo.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> 0352.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaffer Convalescent Retreat, 1935 Old Frederick Rd.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frances M. Quinn Layton</u>				4. DATE OF DEATH Month Day Year <u>Dec. 21 19 56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1890</u>	9. AGE (In years last birthday) yrs. <u>66</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk, Baltimore Transit Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Matthew Quinn</u>				14. MOTHER'S MAIDEN NAME <u>Mary Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>212-03-9732</u>		17. INFORMANT Address <u>Mr Jack Quinn, 6206 Frederick Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized convulsions</u> <u>170X</u> DUE TO <u>Convulsion breast (right)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 yrs</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 1950</u> to <u>12/21</u> , 1956, that I last saw the deceased alive on <u>12/30</u> , 1956, and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Phos E. Roach</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>3629 Edmondson Ave Balto-29-4401</u> <u>12/23/56</u>			
PHYSICIAN'S NAME (Type) <u>THOS E ROACH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HARRY H. WITZKE</u>				ADDRESS <u>4101 Edmondson Ave</u>		24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. E. Longhorne</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12577

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City rural				c. LENGTH OF STAY IN 1b Ellicott City rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Orchard				d. STREET ADDRESS Pine Orchard			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First NANNIE Middle AGNES Last LEDBETTER				4. DATE OF DEATH Month Dec. Day 28 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-9-1899	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tenn	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Wm. E. Thurman				14. MOTHER'S MAIDEN NAME Fannie Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT William E. Ledbetter, Ellicott City, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas with metastases 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 8 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 1, 1956 , to Dec 28, 1956 , that I last saw the deceased alive on Dec 28 , 19 56 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ellicott City, Md DATE SIGNED 1/30/56 ACTUAL SIGNATURE Ben B. L. L. L. M.D. Ellicott City, Md PHYSICIAN'S NAME (Type) Dr. L. A. Kochman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-56		22c. NAME OF CEMETERY OR CREMATORY Pleasant Hill		22d. LOCATION (City, town, or county) (State) Monrovia, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR AN 2 1957		24b. REGISTRAR'S SIGNATURE J. E. Longfellow	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12578 CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH o. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Columbia Pike		d. STREET ADDRESS Columbia Pike	
3. NAME OF DECEASED (Type or print) First Middle Last MORDECAI LEWIS DAWSON LEE		4. DATE OF DEATH Month Day Year December 10, 1956.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 10, 1887.
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Columbus O'Donnell Lee		14. MOTHER'S MAIDEN NAME Hannah A. Tyson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W. I 218-14-6133	
17. INFORMANT Mrs. M.L. Dawson Lee		Address Columbia Pike Ellicott City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, basal DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATHEROSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatic Fibrosis			INTERVAL BETWEEN ONSET AND DEATH 15 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-10-56, 19, to 12-10-56, 19, that I last saw the deceased alive on 12-10-56, 19, and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald E. Fisher M.D.		ADDRESS (Street, city or town, state) Ellicott City, Md.	
PHYSICIAN'S NAME (Type) Donald E. Fisher M.D.		DATE SIGNED 12-11-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 1956.	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	22d. LOCATION (City, town, or county) (State) Petersville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville 28, Md.		24a. REC'D BY REGISTRAR DATE Dec. 14, 56	24b. REGISTRAR'S SIGNATURE John B. Loughran, Jr. B.E.X.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12579 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6330 Old Washington Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Borris</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 10 1862</u>	9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Elkridge Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Michael Borris</u>				14. MOTHER'S MAIDEN NAME <u>Bridget Gibbons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <u>Mrs. Thos L Bush 6330 Old Wash Rd</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic</u> <u>chronic obstructive</u> DUE TO (c) <u>General arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 mo</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>2-20-10, 1926</u> , to <u>2-20-14, 1936</u> , that I last saw the deceased alive on <u>2-20-14, 1936</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1609 Main St Elkridge</u> DATE SIGNED <u>27 Nov 1956</u>							
ACTUAL SIGNATURE <u>B B Brumbaugh</u> M.D.							
PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>		22d. LOCATION (City, town, or county) (State) <u>Elkridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Gorman 901 Hollis St</u> ADDRESS				24a. REC'D BY REGISTRAR <u>17 1956</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Edwin Williams</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

DEC 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G209 1-4-51 et

12580

CERTIFICATE OF DEATH

Reg. Dist. No.

12562/91

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Highland Manor Nursing Home		d. STREET ADDRESS 1504 N. Gay St. Church Lane	
3. NAME OF DECEASED (Type or print) First Mollie Middle Onesta Last Onesta		4. DATE OF DEATH Month December Day 20 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1886
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John J. Buschelberger		14. MOTHER'S MAIDEN NAME Isabel Mayer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John J. Buschelberger		Address 3207 Foster Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis Hard Heart DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Sigmoid; Resected.		INTERVAL BETWEEN ONSET AND DEATH Immediate See you.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/1 , 19 56 , to 12/20 , 19 56 , that I last saw the deceased alive on 12/16 , 19 56 , and that death occurred at 6:48 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm J. Lilly		ADDRESS (Street, city or town, state) Balt Nat Bldg	
PHYSICIAN'S NAME (Type) Lilly & Zeiler Inc.		DATE SIGNED 12/20/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 22, 1956	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.		ADDRESS 403 S. Wolfe Street	
24a. REC'D BY REGISTRAR DEC 26 1956		24b. REGISTRAR'S SIGNATURE J. E. Laughlin	

CERTIFICATE OF DEATH

Name of Deceased John J. [illegible]		Sex Male	
Date of Birth [illegible]		Age [illegible]	
Place of Birth [illegible]		Usual Residence [illegible]	
Date of Death [illegible]		Cause of Death [illegible]	
Physician [illegible]		Medical Examiner [illegible]	
Burial Place [illegible]		Date of Burial [illegible]	
Name of Undertaker [illegible]		Signature of Registrar [illegible]	
Name of Informant [illegible]		Signature of Informant [illegible]	

BUREAU V. 1

DEC 26 1956

RECEIVED

12581

CERTIFICATE OF DEATH

12563

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>H---</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Highland Manor Nursing</i>				d. STREET ADDRESS <i>3107 Northern Parkway</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Miss Elizabeth G. Schirle</i>				4. DATE OF DEATH Month Day Year <i>December 20th 19 56</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 7, 1866</i>		9. AGE (In years last birthday) <i>90</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Newport, Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Anthony Schirle</i>				14. MOTHER'S MAIDEN NAME <i>Katharine</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Francis S. Hossbach, 1617 Northern Pkwy</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10/1</i> , 19 <i>56</i> , to <i>12/20</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>12/16</i> , 19 <i>56</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Max J. Nick</i>		M.D. <i>5226</i>		ADDRESS (Street, city or town, state) <i>Baltimore, Md</i>		DATE SIGNED <i>12/20/56</i>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/21/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road.</i>		24a. REC'D BY REGISTRAR <i>DEC 26 1956</i>	
				24b. REGISTRAR'S SIGNATURE <i>J. E. Longh...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 26 1956

BUREAU V. 3.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BUREAU OF VITALS
CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: _____
3. AGE: _____
4. DATE OF BIRTH: _____
5. PLACE OF BIRTH: _____
6. OCCUPATION: _____
7. CAUSE OF DEATH: _____
8. MANNER OF DEATH: _____
9. PLACE OF DEATH: _____
10. DATE OF DEATH: _____
11. SIGNATURE OF REGISTRAR: _____
12. SIGNATURE OF PHYSICIAN: _____
13. SIGNATURE OF CORONER: _____
14. SIGNATURE OF JURY: _____
15. SIGNATURE OF WITNESSES: _____
16. SIGNATURE OF DECEASED: _____
17. SIGNATURE OF NEXT OF KIN: _____
18. SIGNATURE OF CLERGYMAN: _____
19. SIGNATURE OF CHURCH: _____
20. SIGNATURE OF FUNERAL HOME: _____
21. SIGNATURE OF BURIAL PLACE: _____
22. SIGNATURE OF CREMATOR: _____
23. SIGNATURE OF INTERMENT: _____
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100. SIGNATURE OF REINTERMENT: _____

Item 12 Film 209 1-4-57 et
 12592 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12592 CERTIFICATE OF DEATH

1256491

Reg. Dist. No. 100

1. PLACE OF DEATH o. COUNTY <i>Howard</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ELLICOTT CITY</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	
c. LENGTH OF STAY IN 1b <i>11 months</i>		d. STREET ADDRESS <i>08x-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>HIGHLAND MANOR NURSING HOME</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>PEARL</i> Middle <i>SIMPSON</i> Last <i>SIMPSON</i>		4. DATE OF DEATH Month <i>12</i> Day <i>24</i> Year <i>1956</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9 68</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> DUE TO <i>Brachio pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>arteriosclerotic Cardio-Vascular Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12-21-56</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12-21</i> , 19 <i>56</i> , to <i>12-24</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>12-21</i> , 19 <i>56</i> , and that death occurred at <i>1:30</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George E. Burgtorf</i> M.D.		ADDRESS (Street, city or town, state) <i>ELLICOTT CITY, Md.</i>	
PHYSICIAN'S NAME (Type) <i>GEORGE E. BURGTORF</i>		DATE SIGNED <i>12-24-56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-27-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Church of God Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Cedarville Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Preheat Inc La Plata Md</i>		24a. REC'D BY REGISTRAR <i>DATE 12/27/56</i>	24b. REGISTRAR'S SIGNATURE <i>Julia H. Pary</i>

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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1957

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12583

CERTIFICATE OF DEATH

Reg. Dist. No.

12565

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City rural		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 40				d. STREET ADDRESS Rt. 40			
3. NAME OF DECEASED (Type or print) MAMIE ELIZABETH STIRN		First Middle Last		4. DATE OF DEATH December 30, 1956		Month Day Year 19	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-23-1893	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hebbville, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Edward Sauter		14. MOTHER'S MAIDEN NAME Rosie E. Penn					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT William F. Stirn, Ellicott City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast with metastasis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 yrs -					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August, 1953 , to Dec 30, 1956 , that I last saw the deceased alive on Dec 29, 1956 , and that death occurred at 9A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Ellicott City, Md.		DATE SIGNED Jan 2 1957			
ACTUAL SIGNATURE Dr. H. A. Hochman		M.D.					
PHYSICIAN'S NAME (Type) Dr. H. A. Hochman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Randallstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higginbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR JAN 2 1957		24b. REGISTRAR'S SIGNATURE J. E. Loughery	

BUREAU V. S.

JAN 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waterville Rd.		c. LENGTH OF STAY IN 1b POPLAR SPRINGS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First LOUIS Middle HOWARD Last STULL		4. DATE OF DEATH Month Dece. Day 11 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-24-1902
9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FLEETON STULL		14. MOTHER'S MAIDEN NAME CORA STALEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-16-2253	
17. INFORMANT CELETTA F. BLOOM, MT AIRY Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned 20c. TIME OF INJURY Month, Day, Year Hour found: 12/11 a. m. _____ p. m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) road 20f. (City or town) (County) (State) Howard Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		DATE SIGNED 12/12/56	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-14-56	22c. NAME OF CEMETERY OR CREMATORY ZION	22d. LOCATION (City, town, or county) (State) CHARLESVILLE Md.
23. FUNERAL DIRECTOR'S SIGNATURE F.C. HIGINBOTHAM, GILLOTT CITY MD		24a. REC'D BY REGISTRAR DEC 17 1956	
24b. REGISTRAR'S SIGNATURE H. Hedrich			

MEDICAL CERTIFICATION

13

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File-pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 11
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dec. 11 1956

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DEC 17 1956

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12595

CERTIFICATE OF DEATH

12567

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups P. O.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Greenway Motor Courts				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOSEPH Middle WASILAUSKAS Last WASILAUSKAS				4. DATE OF DEATH Month Dec. Day 4, Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1857		9. AGE (In years last birthday) 99 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -			10b. KIND OF BUSINESS OR INDUSTRY Lithuania		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Joseph Wasilauskas				14. MOTHER'S MAIDEN NAME Helen (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. John Ladusky - Jessups, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure, Pulmonary Embolism 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) auricular fibrillation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 1953 , to 4 Dec 1956 , that I last saw the deceased alive on 4 Dec 1956 , and that death occurred at 11 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George E. Grolean M.D.				ADDRESS (Street, city or town, state) MAINT ST ELKBRIDGE MD			
DATE SIGNED 5 Dec 56							
PHYSICIAN'S NAME (Type) GEORGE E. GROLEAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/56		22c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre Cem.		22d. LOCATION (City, town, or county) (State) Phila., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto 17th				ADDRESS		24a. REC'D BY REGISTRAR DATE 12/6/56	
				24b. REGISTRAR'S SIGNATURE E. Bud Williams			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

